

Upstate Medical Physics Data Form for Evaluating Fetal Dose for Pregnant Patient Diagnostic X-ray or Fluoroscopic Examination

In order to accurately assess the dose to the fetus following a diagnostic X-ray or fluoroscopic examination, it is necessary to obtain specific information related to the examination. Please complete the information below. Fax or e-mail this information to Upstate Medical Physics, Inc. as soon as possible following the diagnostic imaging procedure.

Date form is completed _____

Name of RSO _____

Patient Information

Facility Name _____

Non-PHI patient identifier* _____

Referring Physician _____

* Examples of PHI: names, medical record number, address, birth date, admission date, exam date, discharge date, and other examples at www.hipaa.com/2009.

Examination Information

Room # _____

Type of Examination _____

Equipment Manufacturer & Model _____

XS S M L XL XXL

Height _____ Inches
 Weight _____ lbs.

If Fluoro Study:
 Dimensions of Abdomen
 AP _____ cm
 LAT _____ cm

# of Radiographic Exposures	Exam	View	Film Size	Collimation evident or gonadal shield used? Yes No	Is Uterus in beam? For abdominal, list distance from uterus to inferior scan margin Yes No	X-Ray Techniques kVp mAs SID
<input type="text"/>	_____	_____	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	_____	_____	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	_____	_____	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/> <input type="text"/>

# of Digital Spots	Is Uterus in beam? For abdominal, list distance from uterus to inferior scan margin Yes No	Digital/Spot Techniques kVp mAs
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/>

Fluoro Time	Fluoro Mag Mode	Is Uterus in beam? For abdominal, list distance from uterus to inferior scan margin Yes No	Fluoro Techniques kVp mA	Cumulative Air Kerma mGy
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/>	<input type="text"/> mGy
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> _____ cm	<input type="text"/> <input type="text"/>	

Was the patient known to be pregnant before the exam? Yes No

Was the conceptus seen on the image? Yes No

Any previous exposure to radiation during this pregnancy? Yes No

I acknowledge that this completed form contains no PHI

Initials

 Name of Person Completing this Form

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Phone number to call if further information is required

We recommend that you save a copy of this completed form for your records. After saving the completed form you can e-mail it to fetaldose@upstatemp.com. In order to confirm receipt of this information, you may contact Upstate Medical Physics at 585-924-0350. If you choose to fax this form, our fax number is 585-924-5765.